

# Minnesota Board of Nursing

## *For Your Information*



### Inside this issue:

President's Message	1
NCSBN Simulation Study	1
Delegation & Assignment in the Nurse Practice Act	2
NCSBN Learning Extension	3
Public Health Nurse Registration	3
Legislative Updates	4-5
Board Members	6

- ♦ Minnesota Board of Nursing reintroduces the quarterly newsletter *For Your Information*
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[www.nursingboard.state.mn.us](http://www.nursingboard.state.mn.us)

Summer 2014

Volume 21, Issue 2

### President's Message: Deb Haagensen, RN



One of the most difficult challenges for the Board of Nursing to address is nurses who are struggling with a substance use disorder (commonly termed chemical dependency or addiction.)

I also know it is a challenge for many of us in practice settings who know a colleague facing these struggles.

The National Council of State Boards of Nursing (NCSBN) has a number of resources to support our understanding around substance use disorder. Boards of Nursing are members of NCSBN whose mission is to provide education, service, and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. In addition to being a valuable resource to Boards of Nursing, many NCSBN resources are also available to nurses and the general public (<https://www.ncsbn.org/2106.htm>)

Some NCSBN resources of note include:

- What you need to know about Sub-

stance Use disorder in Nursing (free brochure)

- Nurse Managers Guide to Substance Use Disorder in Nursing (free brochure)
- Substance Use Disorder in Nursing (free video link)
- Understanding Substance Use Disorder in Nursing (on-line CEU opportunity) (continued on page 5)
- Nurse Manager Guidelines for Substance Use Disorder (on-line CEU opportunity)

Other resources available at the link above include articles from the *Journal of Nursing Regulation* on substance use disorder and the "Substance Use Disorder Manual". I have found a number of these resources valuable tools in supporting my own understanding and have shared them with other nursing colleagues. I hope you might also find benefit and support in the above resources. The more we understand about substance use disorder, the better prepared we will be to implement effective strategies that protect patients and support nurses.

### NCSBN National Use of Simulation in Nursing Education Study

Simulation of patient care is one strategy used by nursing education programs to assist students in developing needed skills and clinical judgment. Simulation can take many forms, and ranges from something as simple as a manikin that helps a student learn how to start an IV to something more complex, such as a manikin that is programmed to present a changing patient condition in response to interventions implemented by nursing students.

(continued on page 6)

## Delegation and Assignment in the Minnesota Nurse Practice Act

In August 2013, revisions to the definitions of professional and practical nursing in the Minnesota Nurse Practice Act (NPA, <http://mn.gov/health-licensing-boards/nursing/laws-and-rules/nurse-practice-act>) went into effect. The NPA provides definitions of practical, professional and advanced practice registered nursing and provides legal parameters to the scope of practice for nurses. The revisions to the NPA were intended to clarify areas of practice that have historically been confusing. The role of the LPN and the RN in delegation and assignment are addressed in this issue of the newsletter.

The term delegation is often used to describe the process of directing others to perform nursing tasks. In some cases, directing others is a method to distribute work among the available staff. In other instances, accomplishment of the task requires the transfer of authority to perform the task, under specific circumstances. The revised NPA distinguishes these two activities.

**Assignment** means the designation of nursing tasks or activities to be performed by another nurse or unlicensed assistive personnel (“UAP”). This is essentially the division of work – who is going to do what? The assigned tasks or activities are those that are already in the scope of the nurse or in the area of authorization for the UAP. The scope of practice for the LPN includes assigning nursing activities or tasks to other LPNs or to UAP. The LPN scope also includes monitoring UAP performing assigned tasks.

**Delegation** means the transfer of authority to another nurse or competent UAP to perform a specific nursing task or activity in a specific situation. Delegation requires transfer of authority and, in this way, is distinct from assignment. Effective delegation requires consideration of the complexity of the task to be performed, the skill and competence of the individual performing the activity, the condition of the patient, and the supervision available. Because of the numerous variables that must be considered, delegation is situation-specific. The scope of practice for the registered nurse includes delegating nursing tasks or assigning nursing activities to implement the plan of care.

**Monitoring** means the periodic inspection by an RN or LPN of a delegated or assigned nursing task or activity and includes watching during the performance of the task or activity, periodic checking and tracking of progress, updating a supervisor on the progress or completion of the activity, and contacting a supervisor as needed for consultation.

**Supervision** means the guidance by a registered nurse in the accomplishment of a nursing task or activity. It consists of monitoring as well as establishing the initial direction, delegating, setting expectations and courses of action, evaluating and changing a course of action.

The practice act makes it clear that assignment is within the scope of practice for the LPN and the RN and that the RN may also delegate. The NPA does not provide a “laundry list” of tasks that may or may not be assigned or delegated nor does it specify how the requisite monitoring and supervision should be accomplished. This is because of the many and varied settings in which nursing is practiced, the wide range of patient conditions, varying employer policies and procedures, and differing levels of knowledge, skill and abilities of the nurses and UAP to whom tasks may be assigned and delegated. Additional information about the process of delegation may be obtained from the American Nurses Association and the National Council of State Boards of Nursing (See [https://www.ncsbn.org/Delegation\\_joint\\_statement\\_NCSBN-ANA.pdf](https://www.ncsbn.org/Delegation_joint_statement_NCSBN-ANA.pdf) and [https://www.ncsbn.org/Working\\_with\\_Others.pdf](https://www.ncsbn.org/Working_with_Others.pdf)).

## National Council of State Boards of Nursing Learning Extension

The mission of the National Council of State Boards of Nursing (NCSBN) is to provide education, service and research through collaborative leadership to promote evidence-based regulatory excellence for patient safety and public protection. Continuing education for nursing students, licensees, and faculty is offered by NCSBN through “The Learning Extension”. Courses are affordable, with many priced at less than \$30.00 for 3 contact hours, payable to the NCSBN. Educational content areas include various state nurse practice acts (including an updated module on the Minnesota Nurse Practice Act), ethics in nursing, delegation, professional boundaries, error detection and prevention, and more. Links to the course on state Nurse Practice Acts and to the course catalogue are below.

Online self-paced state nurse practice act continuing education courses:

[http://learningext.com/nurses/p/nurse\\_practice\\_acts.aspx](http://learningext.com/nurses/p/nurse_practice_acts.aspx)

NCSBN Learning Extension web page: <http://learningext.com/>

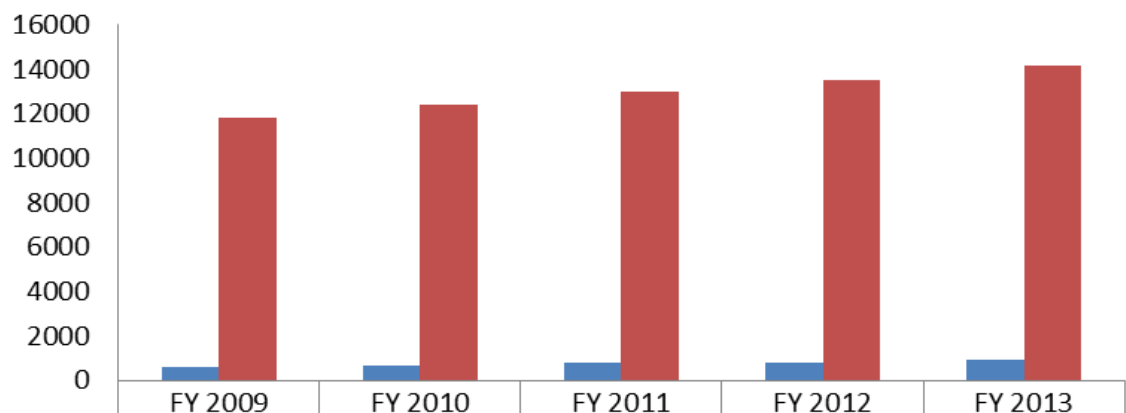


## Public Health Nurse Registration

Registered nurses who have completed a baccalaureate or higher degree with a major in nursing, who are licensed and have current Minnesota registration are able to obtain registration as a public health nurse (PHN).

Registration as a Public Health Nurse is voluntary, but only a nurse who is registered may use the designation “PHN” as part of their credentials. As of June 2014, 14,955 nurses hold this certification. More information and the packet for application can be found at: <http://mn.gov/health-licensing-boards/nursing/licensees/licensure/public-health-nurse-registration.jsp>

### Public Health Nurse certificates, FY 2009-2013



Certificates issued	602	700	805	773	931
Total certificate holders	11,822	12,380	13,001	13,530	14,147

## Legislative Updates

The 2014 Legislature enacted amendments to the Nurse Practice Act and Chapter 214 affecting the authority of the Board of Nursing and all health-related licensing boards in disciplinary matters. HF2402 was an omnibus health professionals licensing bill, which also further defined the circumstances under which the Health Professional Services Program Manager must report program participants to an appropriate health-related licensing board, such as the Board of Nursing.

The Nurse Practice Act (Minnesota Statutes sections 148.171 through 148.285) was amended to state the Board may not grant or renew a license if the individual has been convicted on or after August 1, 2014 of criminal sexual conduct in the first through fourth degree. A license to practice nursing is automatically revoked if the licensee is convicted of one of these crimes. Additionally, the Board is exempt from the Criminal Rehabilitation Act (Minn. Ch. 364) for purposes of denial of license or renewal or revocation for conviction of criminal sexual conduct.

Chapter 214 applies to all health-related licensing boards, including the Board of Nursing. The revisions enacted are:

1. All health-related licensing boards must suspend the license of a health care professional if there is probable cause to believe the licensee's continued practice presents imminent risk of harm. There are specific time requirements for notice to the individual and action on the license.
2. Boards must include information about the Health Professionals Services Program (HPSP) on the respective board's website.
3. Boards must contract with the HPSP for monitoring services of individuals who are unable to practice with reasonable skill and safety by reason of illness, including substance use disorders. Currently, the law provides that a board must conduct a program or contract for a program.
4. There is a provision related to the temporary suspension of a license, i.e. if a licensee is discharged from HPSP based on allegations that might pose a risk to the public, and the Board has probable cause to believe continued practice is an imminent risk of harm to the public, the Board **MUST** temporarily suspend the license. There are specific time requirements to completion of the investigation and action.
5. The HPSP Program Manager is required to report to the appropriate health-related licensing board if the licensee:
  - Does not meet program admission criteria.
  - Violates the terms of the program participation agreement.
  - Leaves or is discharged from the program (other than for successful completion).
  - Is infected with HIV/HBV/HCV and subject to Minnesota Statutes sections 214.17-214.25.
  - Causes identifiable patient harm.
  - Unlawfully substitutes or adulterates medications.
  - Writes a prescription or causes a prescription to be dispensed in the name of a person other than the prescriber or veterinary patient for the personal use of the prescriber.
  - Alters a prescription without the knowledge of the prescriber for the purpose of obtaining a drug for personal use.
  - Unlawfully uses a controlled or mood-altering substance, or uses alcohol, while providing patient care, or while on call, or otherwise on duty if current use is the reason for participation, or the use occurs while participating in program.
  - Violates the governing practice act.
6. Employers must report to the board knowledge of diversion of narcotics or controlled substances if the diversion occurred at their facility. There are some exceptions: An employer is not required to report if the knowledge was obtained in a professional patient relationship and the regulated person is a patient or if the diversion becomes known to the employer by way of a worksite monitor through the HPSP.
7. Discharge or leaving the HPSP for reason other than satisfactory completion of a monitoring agreement is grounds for disciplinary action.

The Nurse Practice Act was also amended to require licensure for advanced practice registered nurses (APRNs), and removes the requirement for a collaborative management agreement and written prescribing agreement. After the effective date of January 1, 2015, individuals will be required to be licensed as an APRN

## Licensure

To become licensed, an APRN will be required to hold a current RN license, submit documentation of successful completion of an acceptable graduate APRN program and hold current certification by a national nurse certification organization acceptable to the board as a clinical nurse specialist (CNS), certified nurse practitioner (CNP), certified registered nurse anesthetist (CRNA), or certified nurse midwife (CNM) in one of the 6 population foci. APRNs who have more than one role, will be issued a license for each role as applicable (CNS, CNP, CNM, CRNA). APRNs who do not meet the educational requirements but are recognized by the Board to practice as an APRN on July 1, 2014, will be eligible for licensure.

## Post-graduate practice

Prior to full independent practice and prescribing authority, CNSs and CNPs will be required to practice for 2,080 hours within the context of a collaborative agreement with a licensed Minnesota CNS, CNP, or physician who has experience in providing care to patients with similar medical problems. Currently practicing CNSs and NPs may already meet this requirement. A post-graduate practice component is not required for CNMs or CRNAs.

## Scope of practice

The scope and standards of an APRN are defined by the national professional nursing organizations specific to the practice as a CNS, CNM, CNP, or CRNA in the specific population focus. The scope includes but is not limited to performing acts of advanced assessment, diagnosing, prescribing, and ordering. The practice includes function as a primary care provider, direct care provider, case manager, consultant, educators and researcher.

APRNs are accountable to patients for the quality of APRN care rendered, recognizing the limits of knowledge and experience, planning for the management for situations beyond the APRNs expertise. APRNs accept referrals, consult with, collaborate with and refer to other health care providers as warranted by the needs of the patient. APRNs may order, perform, supervise, and interpret diagnostic studies, excluding interpreting computed tomography scans, magnetic resonance imaging scans, positron emission tomography scans, nuclear scans, and mammography.

## Credentials to be used to identify authority to practice as an APRN

Credentials to be used by licensed APRNs are Jane Doe APRN, CNS; Jane Doe APRN, CNP, Jane Doe APRN, CNM, Jane Doe APRN, CRNA. Educational degrees may be added.

## Pain management by CRNAs

A CRNA may perform nonsurgical therapies for acute and chronic pain symptoms upon referral and in collaboration with a Minnesota licensed physician. The CRNA and the one or more physician must have a mutually agreed upon plan that designates the scope of collaboration needed for providing nonsurgical therapies to patients with acute and chronic pain. The CRNA must perform the nonsurgical therapies at the same licensed health care facility as the physician. For the purposes of providing nonsurgical pain therapies for chronic pain symptoms, a CRNA must have a written prescribing agreement with a licensed Minnesota physician that defines the delegated responsibilities related to prescribing drugs and therapeutic devices within the scope of the agreement and the practice of the CRNA.

The board is preparing the processes required to implement the new law. Applications for APRN licensure will be accepted beginning in Fall 2014. More detailed information about the law can be accessed here: <https://www.revisor.mn.gov/bills/bill.php?b=Senate&f=SF0511&ssn=0&y=2014>.

There were also changes to the Prescription Monitoring Program (PMP) which may also affect nurses. (Minnesota Statutes section 152.126) The purpose of the PMP is to promote public health and welfare by detecting diversion, abuse and misuse for the prescription medications classified as controlled substances under Minnesota law. Prescribers may access the PMP to review and monitor the prescriptions for controlled substances of individuals. Tramadol and Butalbital are now considered controlled substances for purposes of the PMP and these drugs will now appear on PMP reports.

All of the provisions listed above become effective either July 1, 2014 or August 1, 2014. Visit the web site of the Minnesota Revisor of Statutes ([revisor.state.mn.us](http://revisor.state.mn.us)) to access the laws in detail.



### Minnesota Board of Nursing

Link to Board member profiles:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

How to become a Board member:

<http://mn.gov/health-licensing-boards/nursing/about-us/about-the-board/current-board-members.jsp>

## Minnesota Board of Nursing Members

Board Member Name	Board Role
Cindy DeJarlais	LPN Member
Jeanine Gangeness	RN Member
Deborah Haagenson	RN, Board President
Michelle Harker	Public Member
June McLachlan	RN Member
Deborah Meyer	LPN member
Christine Norton	Public Member
Monica Parks	RN Member
Jan Rainey	Public Member
Christine Renne	Public Member
Julie Riportella	LPN Member
Sheila Robley	LPN Member
Diane Scott	RN Member
Sue Sendelbach	RN Member, Board Secretary
Steven Strand	RN Member
Natya Stroud	RN Member

(continued from page 1) In 2010, the National Council of State Boards of Nursing (NCSBN) embarked on an ambitious multi-year study to identify current practices regarding the use of simulation and to determine whether there were best practices in the use of simulation to guide program approval practices and assist educators. In Phase I, baseline information regarding the use of simulation in professional nursing programs was collected from 1,060 pre-licensure professional nursing programs. Phase II was a randomized, controlled study that varied the amount of clinical learning experience time that was replaced by simulation. In this phase, 667 nursing students in one of 10 nursing programs (5 associate degree programs and 5 baccalaureate programs) were randomly placed into a group that received traditional clinical learning experiences, a group that had 25% of the clinical learning time replaced with simulation, or a group that had 50% of the clinical learning time replaced with simulation. Prior to their graduation in May 2013, study participants completed a competency assessment. Most of the study participants (587 of 667) agreed to participate in the final phase of the study. In Phase III, data on perceived readiness to practice and performance on the NCLEX-RN® examination is being collected. Data collection will end in December 2014. The results of this longitudinal study will provide useful information regarding the use of simulation in nursing education. Details of the simulation study can be found at:

<https://www.ncsbn.org/2094.htm>